10021

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

**1. PLACE OF DEATH:**
County CHARLES - La Plata Md.
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred: .....
How long in hospital or institution? .....

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Spring Hills County Maryland
City or town Charles Co. X (If outside city or town limits, write RURAL and give nearest town)
Street No. 08X-1 (If rural, give LOCATION)
2.(a) If veteran, name war .....

**3. (a) FULL NAME** Dennis Campbell

**3. (b) Social Security Number**

4. Sex: Male
5. Color or race: Negro
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Julia Campbell
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.)

**8. AGE:** Years 67 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace La Plata Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Joe Campbell
13. Birthplace Md
MOTHER 14. Maiden name Julia Cole
15. Birthplace
16. Informant Julia Campbell
Address La Plata Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 8 1953 (month) (day) (year)
Cemetery or crematory St Mary
Location Newport Md
18. Funeral director Johnson & Jenkins
Address 2053 Gal. Ave. N.W.
19. 10/5/53 (Date rec'd by registrar) 19 ..... Julia H Pasey Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1953, at 10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h 19 alive on 10-3-53

| Immediate cause of death | DURATION |
|---|---|
| Subarachnoid | |
| Due to hemorrhage | 10-3-53 |
| Due to | |
| Other conditions 330X (Include pregnancy within 3 months of death) | |

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C. J. Edelin M.D. M. D. or other
Address La Plata Md. Date signed 10-4-53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS A13 9-45-15M

RECEIVED
OCT 7 1953
BUREAU V. S.

10022

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH — COUNTY: Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Marshall Hall — LENGTH OF STAY (in this place): 4 Mths
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Marshall Hall Md
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Mamie Forsee Collender
4. DATE OF DEATH (Month) (Day) (Year): 10 14 53
5. SEX: Female
6. COLOR OR RACE: W US
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: 10-18-76
9. AGE last birthday: 76 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nashville Franklin Tenn. U.S.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wade Forsee
14. MOTHER'S MAIDEN NAME: Mary Collins Davis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Fisher C Parodi

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1

Immediate cause (a) Coronary Occlusion — 3 C Hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Heart Disease — 8 Mths

(c) Valvular Heart Disease — Indefinite

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-14, 1953, to 10-14-53 19....., that I last saw the deceased alive on 10-14, 1953, and that death occurred at 12:50 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
James E. Andrews Marshall Hall Md 10-14-53

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF: 10/15/53. — NAME OF CEMETERY OR CREMATORY: Mt. Hope — LOCATION (City, town, or county) (State): Franklin, Tenn.

DATE REC'D BY LOCAL REG.: Oct. 13, 1953 — REGISTRAR'S SIGNATURE: Connie J. Campbell — 24. FUNERAL DIRECTOR: W. W. CHAMBERS, Riverdale, Md. — ADDRESS

Odey Price

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A

RECEIVED
OCT 28 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10023

# CERTIFICATE OF DEATH

Reg. Dist. No. 100

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY CHARLES MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - SPRING HILL
LENGTH OF STAY (in this place) LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY CHARLES
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - SPRING HILL
STREET ADDRESS (If rural give location) ROUTE #6 MARYLAND

3. NAME OF DECEASED: (Type or Print) (First) THOMAS (Middle) FORD (Last) COOKSEY

4. DATE OF DEATH: (Month) OCTOBER (Day) 22 (Year) 19 1953

5. SEX: MALE
6. COLOR OR RACE: CAUCASIAN-US.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: OCTOBER 12, 1883
9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JAMES C. COOKSEY
14. MOTHER'S MAIDEN NAME: SUSAN CASH

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) 1905-1909
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: MRS. NELLIE COOKSEY

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| 420.1 Immediate cause | (a) CORONARY THROMBOSIS, ACUTE | 4 HOURS |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | DUE TO (b) CORONARY SCLEROSIS (ANGINA PECTORIS) | 3 YEARS |
| | DUE TO (c) GENERALIZED ARTERIO-SCLEROSIS | 5 YEARS |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) — (COUNTY) — (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from JULY, 1947, to OCTOBER, 1953, that I last saw the deceased alive on OCTOBER 22, 1953, and that death occurred at 8.50 AM, from the causes and on the date stated above.

SIGNATURE John H. Griffin (Degree or title) M.D. ADDRESS Hughesville M.D. DATE SIGNED October 22, 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Oct. 25, 1953
NAME OF CEMETERY OR CREMATORY Trinity
LOCATION (City, town, or county) (State) New Port, Md.

DATE REC'D BY LOCAL REGISTRAR 10/25/53
REGISTRAR'S SIGNATURE Julia H. Pasey
24. FUNERAL DIRECTOR Hewitt Funeral Home ADDRESS Waldorf Md

RECEIVED
OCT 28 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10024

# CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-15 8-51

**1. PLACE OF DEATH:**
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata
LENGTH OF STAY (in this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Port Tobacco X
STREET ADDRESS (If rural, give location)

**3. NAME OF DECEASED: (Type or Print)** (First) Annie (Middle) Amelia (Last) CROFT

**4. DATE OF DEATH:** (Month) Oct. (Day) 12 (Year) 1953

**5. SEX:** F.

**6. COLOR OR RACE:** W.

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** M.

**8. DATE OF BIRTH:** Sept. 20, 1907

**9. AGE last birthday:** 46 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housf.

**10b. KIND OF BUSINESS OR INDUSTRY:** own home

**11. BIRTHPLACE** (State or foreign country): Md.

**12. CITIZEN OF WHAT COUNTRY?** US

**13. FATHER'S NAME:** Edward Della

**14. MOTHER'S MAIDEN NAME:** Sophia Rice

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) — (If Yes, give war or dates of service) —

**16. SOCIAL SECURITY NO.:** —

**17. INFORMANT & ADDRESS:** Russell Croft, Port Tobacco, Md

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| 24 hr. Immediate cause | (a) Acute Congestive Heart Failure | 1 hr. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) Chronic bronchial asthma | 15 yr. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** 0

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY — M. — INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/7, 1953, to 10/12, 1953, that I last saw the deceased alive on 10/11, 1953, and that death occurred at 6:15 A.m., from the causes and on the date stated above.

SIGNATURE Richard Daly — (DEGREE OR TITLE) M.D. — ADDRESS La Plata, Md. — DATE SIGNED 10/12/53

**23. BURIAL, CREMATION REMOVAL (Specify):** Burial — DATE THEREOF 10/14/53 — NAME OF CEMETERY OR CREMATORY Denhamville ME — LOCATION (City, town, or county) (State) Denhamville, Md.

DATE REC'D BY LOCAL REG. 10/13/53 — REGISTRAR'S SIGNATURE Julia H Posey

**24. FUNERAL DIRECTOR** — ADDRESS Hewitt & Ryon, Waldorf, Md.

RECEIVED
OCT 15 1953
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 10025 / 10-2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

COUNTY Charles — MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): X

LENGTH OF STAY (in this place): 67 Yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: X

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE Md. COUNTY Charles

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ironsides, Maryland

STREET ADDRESS (If rural, give location)

**3. NAME OF DECEASED:** (Type or Print) (First) Lemuel (Middle) (None) (Last) Dent

**4. DATE OF DEATH:** (Month) Oct. (Day) 25, (Year) 19 53

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | Widowed | 1-15-1886 | 67 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | Farming | Ironsides | US |

**13. FATHER'S NAME:** Samuel Dent

**14. MOTHER'S MAIDEN NAME:** Hopie Ward

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|---|
| No | | None | Harrison Dent (Brother) |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420,1

Immediate cause — (a) Coronary Occlusion — DUE TO — Interval Between Onset and Death: Immediate

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Hypertension — DUE TO — 5-Years

(c) Arterio-sclerosis General

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Patient dropped dead while attending services at Mt. Hope Baptist Church Ironsides Md

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| 0 | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| M. | | |

22. I hereby certify that I attended the deceased from 10-25-53, 19 10-25-53, to 19....., that I last saw the deceased alive on 10-25-53, 19....., and that death occurred at 1:15 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

James E. Andrews M.D. Ironsides Md 10-25-53

| 23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 31 53 | Mount Hope | Ironsides, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct 31 1953 | J. C. Thompson | Johnson & Jenkins | 2053 Georgia Ave. N.W. |

VS. A 3-51

RECEIVED
NOV 2 1911
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct an... is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. At6A

1. PLACE OF DEATH: COUNTY Charles — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN White Plains
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Lennie (Middle) C. (Last) Tolliver
4. DATE OF DEATH: (Month) 10 (Day) 25 (Year) 1943

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | Widow | 5-15-01 | 42 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Maid | Domestic | Md. | U.S. |

13. FATHER'S NAME: Robert Butler
14. MOTHER'S MAIDEN NAME: Mollie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: William D. Johnson

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

33/X **Immediate cause** (a) Uremia / nephritis — 6-2-5-13

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — ?

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED 10-26-43

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 10/29/43 — NAME OF CEMETERY OR CREMATORY St. Pauls — LOCATION (City, town, or county) (State) Waldorf Md.

DATE REC'D BY LOCAL REG. 10/27/43 — REGISTRAR'S SIGNATURE Julia H Boney — 24. FUNERAL DIRECTOR — ADDRESS Hunt & Ryon, Waldorf Md.

BUREAU V.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1053

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Newourg X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newburg, Md.
STREET ADDRESS (If rural, give location)

**3. NAME OF DECEASED: (Type or Print)** (First) Howard (Middle) M. (Last) NORRIS

**4. DATE OF DEATH:** (Month) October (Day) 15 (Year) 1953.

**5. SEX:** M

**6. COLOR OR RACE:** W

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Widowed

**8. DATE OF BIRTH:** Aug. 1 1880

**9. AGE last birthday:** 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life even if retired) Ret. Post Master

**10b. KIND OF BUSINESS OR INDUSTRY:** Gov.

**11. BIRTHPLACE** (State or foreign country): Wayside, Md.

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Edward Norris

**14. MOTHER'S MAIDEN NAME:** Genette Bailey

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) no (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Howard Norris Jr. Newburg, Md

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1
**Immediate cause** (a) Coronary Thrombosis — Interval Between Onset and Death: 12 hrs.

DUE TO

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Coronary insufficiency & Angina — 2 years.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** —

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☑

**21. ACCIDENT SUICIDE HOMICIDE** (Specify) —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 49, to Oct., 1953, that I last saw the deceased alive on 15 Oct., 1953, and that death occurred at 6:30 A.m., from the causes and on the date stated above.

SIGNATURE J. Woody. (DEGREE OR TITLE) MD ADDRESS La Plata. Md. DATE SIGNED 15 Oct 53

**23. BURIAL, CREMATION REMOVAL (Specify):** Burial

DATE THEREOF 10/17/53

NAME OF CEMETERY OR CREMATORY St. Marys Cemetery

LOCATION (City, town, or county) (State) Newport, Md.

DATE REC'D BY LOCAL REG. 10/17/53

REGISTRAR'S SIGNATURE Julian H Raney

**24. FUNERAL DIRECTOR** Hurtt & Ryon Waldorf, Md. ADDRESS

VS 16 8-51

RECEIVED
OCT 21 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Harford — STATE MARYLAND — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel Air — LENGTH OF STAY (In this place) — HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Distrct of Columbia — COUNTY — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington — STREET ADDRESS (If rural, give location) 829-20th. N.E.

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) (Last) Ross

4. DATE OF DEATH: (Month) 10 (Day) 21 (Year) 1953

5. SEX: F

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: Feb 14, 1883

9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Peter Cunningham

14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. E. Rose, 4219 Benning Rd. N.E. Work. DC.

### 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**Immediate cause** (a) Coronary Occlusion — Interval between onset and death: 24 hr

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) [illegible] — 10-21-53

420.1 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection ___, Inquiry ___ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ___, accident ___, suicide ___, homicide ___, undetermined ___*

SIGNATURE: [illegible] (Degree or title) M.D. — ADDRESS Bel Air, Md. — DATE SIGNED 10-21-53

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF 10/21/53 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State): Washington, DC

DATE REC'D BY LOCAL REG. 10/21/53 — REGISTRAR'S SIGNATURE: Julia H. Posey

24. FUNERAL DIRECTOR: Ralph Barbour — ADDRESS: 49 K St. N.E. Washington, DC.

VS. A15A

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BUREAU V. S.

Item #14 Film G158 10/14/53 mmb

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

10020

Reg. Dist. No. 106

1. PLACE OF DEATH — COUNTY: Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Indian Head — LENGTH OF STAY (in this place): 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Naval Powder Factory

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: New Jersey — COUNTY: ✓
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Egg Harbour
STREET ADDRESS (If rural give location): 636 Washington ave. ✓

3. NAME OF DECEASED (Type or Print): (First) Willie (Middle) Clifford (Last) Walker
4. DATE OF DEATH: (Month) Oct. (Day) 3 (Year) 1953

5. SEX: Male
6. COLOR OR RACE: Negroid
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 5, 1925
9. AGE last birthday: 28 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: ~~unknown~~ Mattie Chapman Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If year, give war or dates of service): to death
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Health Record, U.S. Navy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Rupture, traumatic, heart — unknown

819X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street — (CITY OR TOWN): Marbury — (COUNTY): Charles — (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 3 1953 m.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? Auto accident — [illegible]

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased DOA alive on Oct. 3, 1953, and that death occurred at approx. 2:15 P m., from the causes and on the date stated above.

SIGNATURE: Calvin W. Woodruff — (Degree or title): Lt(jg) MC USNR — ADDRESS: Naval Powder Factory, Indian Head, Md. — DATE SIGNED: Oct. 12, 1953

23. BURIAL, CREMATION, REMOVAL (Specify): — DATE: Oct 3, 1953 — NAME OF CEMETERY OR CREMATORY: U.S. Naval Hospital — LOCATION (City, town, or county): Bethesda, Montgomery — (State): Md.

DATE REC'D BY LOCAL REG.: 10/3/53 — REGISTRAR'S SIGNATURE: Odey Prise

24. FUNERAL DIRECTOR: Eugene Ford — ADDRESS: Wash. D.C. 1293 - 4th St. S.W.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 10546

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 106

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH: COUNTY Charles — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Byrans Road
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Byrans Road
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Cornelius (Middle) Raphael (Last) Washington.

4. DATE OF DEATH: (Month) Oct. (Day) 10 (Year) 1953

5. SEX Male | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH Oct. 5 1953 | 9. AGE last birthday yrs. | If under 1 year: Months | Days 5 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Byrans Road. Md | 12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Henry Sylvester Washington | 14. MOTHER'S MAIDEN NAME Annie Alice Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. — | 17. INFORMANT AND ADDRESS Henry S. Washington (Father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

763.0 Immediate cause (a) Bronchopneumonia — 2 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy __, Inspection __, Inquiry __ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Timothy Semmes D. | Indian Head Md | Oct 10, 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Oct 12-1953 | NAME OF CEMETERY OR CREMATORY Adeedone Baptist | LOCATION (City, town, or county) (State) Byrans Road, Md

DATE REC'D BY LOCAL REG. 10-10-53 | REGISTRAR'S SIGNATURE Maynie E. Ransome Deputy Local Registrar | 24. FUNERAL DIRECTOR Stanley J. Terry Mortuary | ADDRESS Indian Head Md

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10030

# CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf, X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf, Md. X
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Jessie (Middle) (Last) Washington

4. DATE OF DEATH: (Month) Oct (Day) 25 (Year) 1953

5. SEX: F
6. COLOR OR RACE: N
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH: 1898
9. AGE last birthday: 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: House wife
10b. KIND OF BUSINESS OR INDUSTRY: self
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Washington
14. MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 4 no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Thomas Butler Waldorf, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X

Immediate cause (a) Cardio - Vas - Renal Di

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Pro. Sumptuo Gastric Ca

DUE TO

(c)

Interval Between Onset And Death: years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7, 1953, to 10/24, 1953, that I last saw the deceased alive on 10/24, 1953, and that death occurred at Waldorf, from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) M.D. ADDRESS Waldorf Md. DATE SIGNED 10/27/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct. 27, 1953 NAME OF CEMETERY OR CREMATORY Mt. Hope LOCATION (City, town, or county) Thonsides (State) Md.

DATE REC'D BY LOCAL REGISTRAR 10-27-53 REGISTRAR'S SIGNATURE M. L. Monroe
24. FUNERAL DIRECTOR Hunt & Ryan ADDRESS Waldorf, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A

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BUREAU V. S.

FilM #G-159 Item No. 14. 10/26/53 emp

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10031

# CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 20 Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rison X
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) (Last) Washington
4. DATE OF DEATH: (Month) Oct. (Day) 15 (Year) 1953

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.
8. DATE OF BIRTH: Mar. 1, 1905
9. AGE last birthday: 48 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hsw
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Frank Cobey
14. MOTHER'S MAIDEN NAME: Lavine unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Arthur Washington, Rison, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 442X
Immediate cause (a) Cardio Vas - Renal Disease — INTERVAL BETWEEN ONSET AND DEATH 1 yr
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to 10-14 1953 that I last saw the deceased alive on 10-14, 1953, and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE E. J. Edelen (DEGREE OR TITLE) MD ADDRESS La Plata Md DATE SIGNED 10-15-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF 10/18/53
NAME OF CEMETERY OR CREMATORY Oak Grove
LOCATION (City, town, or county) (State) Grayton, Md.
DATE REC'D BY LOCAL REG. 10/19/53
REGISTRAR'S SIGNATURE Julia H Pasey
24. FUNERAL DIRECTOR Hunt + Ryan, Waldorf, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 8-51

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